Cabinet for Health and Family Services

Office of the Kentucky Health Benefit Exchange

(New Emergency Administrative Regulation)

900 KAR 10:010E. Certification of Qualified Health Plans and Qualified Dental Plans.

RELATES TO: 42 U.S.C. § 18031, 45 C.F.R. Parts 155 and 156

STATUTORY AUTHORITY: Executive Order 2012-587, 42 U.S.C. § 18031

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Office of the Kentucky Health Benefit Exchange, has responsibility to administer the state-based American Health Benefit Exchange. Executive Order 2012-587 authorizes the Office to carry out the functions and responsibilities required under Section 1311 of the Affordable Care Act and to promulgate administrative regulations in accordance with KRS 13A, as necessary to carry out the duties and responsibilities of the Exchange. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan to be offered on the Exchange, pursuant to, and in accordance with 42 U.S.C. § 18031 and 45 C.F.R. Parts 155 and 156.

Section 1. Definitions. (1) "Actuarial value" means the percentage paid by a health plan of the percentage of the total allowed costs of benefits.

(2) "Adverse action" means an act on the part of a regulatory authority that negatively affects an issuer, qualified employer, qualified employee, or qualified individual.

(3) "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010 as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010

(4) "Appeal" means a request for a review of an adverse action.

(5) "Benefit year" means a calendar year for which a health plan provides coverage for health benefits.

(6) "Catastrophic plan" means a health plan that is described in and meets the requirements of 45 CFR §156.155.

(7) "Certificate of authority" is defined by KRS 304.1-110.

(8) "Certification" means a determination by the Kentucky Health Benefit Exchange that a health plan has met the requirements in Section 2 of this administrative regulation or a stand-alone dental plan has met the requirements in Section 3 of this administrative regulation.

(9) "Child-only plan" means an individual health policy that provides coverage to an individual under the age of twenty-one (21).

(10) "Consumer Operated and Oriented Plan" or "CO-OP" means a private, non-profit health insurance issuer established in Section 1322 of the Affordable Care Act that has a certificate of authority.

(11) "Department of Health and Human Services" or "HHS" means the U.S. Department of Health and Human Services.

(12) "Department of Insurance" or "DOI" is defined by KRS 304.1-050(2).

(13) "Enrollee" means an eligible individual enrolled in a qualified health plan.

(14) "Essential community provider" means a health care provider:

(a) Defined in Section 340B(a)(4) of the Public Health Service Act; and

(b) Described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act.

(16) "Essential health benefits" means benefits approved by the Secretary of HHS as provided in 42 USC §_____ for the Commonwealth of Kentucky. "Exchange" means the American Health Benefit Exchange as identified in Section 1311(a) of the Affordable Care Act.

(17) "Health plan" is defined by 45 C.F.R. 160.103.

(18) "Health insurance issuer" or "issuer" means as that term is defined in 45 C.F.R. §144.103.

"Health plan form" or "form" is defined by 806 KAR 14:007. "Individual exchange" means the exchange that serves the individual health insurance market."Initial open enrollment period" means the period beginning October 1. 2013 and extending through March 31, 2014 during which a qualified individual or qualified employee may enroll in health coverage through an exchange during the 2014 benefit year.

(a) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based exchange conditionally approved by HHS under standards set forth in 45 C.F.R. § 155.105 to offer QHP's on January 1, 2014. .

(19) "Metal level of coverage" means health care coverage based on a specified share of the full actuarial value of the essential health benefits that shall be a:

(a) Bronze level with an actuarial value of sixty (60) percent, plus or minus two (2) percent;

(b) Silver level with an actuarial value of seventy (70) percent, plus or minus two (2) percent;

(c) Gold level with an actuarial value of eighty (80) percent, plus or minus two (2) percent; and

(d) Platinum level with an actuarial value of ninety (90) percent, plus or minus two (2) percent.

(20) "Multi-state plan" means a health plan that is offered under a contract with the U.S. Office of Personnel Management in accordance with Section 1334 of the Affordable Care Act.

(21) "Office of the Kentucky Health Benefit Exchange" or ""Office" means the office created under Executive Order 2012-587.

(22) "Pediatric dental essential health benefit" means a dental service to prevent disease and promote oral health, restore an oral structure to health and function, and treat an emergency condition provided to an individual under the age of twenty one (21) that meets the requirements of 42 U.S.C. 18022(b)(1)(J).

(23) "Plan year" means a consecutive twelve (12) month period during which a health plan provides coverage for health benefits.

(24) "Premium" is defined by KRS 304.14-030.

(25) "Provider network" is defined by KRS 304.17A-005.

(26) "Qualified dental plan" means a dental plan certified by the KHBE that provides a limited scope of dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including a pediatric dental essential health benefit meeting the requirements of 42 U.S.C. 18022(b)(1)(J).

(27) "Qualified employee" means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

(28) "Qualified employer" means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered in the SHOP.

(29) "Qualified health plan" or "QHP" means a health plan that has an active certification issued by the KHBE that it meets the standards described in 45 C.F.R. 156 Subpart C.

(30) "Qualified individual" means an individual who has been determined eligible to enroll through the KHBE in a QHP in the individual market.

(31) "Rating area" means a geographical area that provides a boundary by which an issuer can adjust a premium.

(32) "Rider" is defined by 806 KAR 17:330.

(33) "Risk adjustment" means a statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

(34) "Service area" means a geographical area in which an individual shall reside or be employed in order to enroll in a QHP.

(35) "SHOP" means a Small Business Health Options Program operated by an exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs pursuant to 45 C.F.R. 155.20.

(36) "Summary of Benefits and Coverage" or "SBC" means a standard format for providing information to consumers about a health plan's coverage and benefits in accordance with Section 2715 of the Public Health Service Act.

(37) "System for Electronic Rate and Form Filing" or "SERFF" means an online system established and maintained by the National Association of Insurance Commissioners (NAIC) that enables an issuer to send and a state to receive, comment on, and approve or reject rate and form filings.

Section 2. Process, Procedure, and Timing for Qualification of an Issuer and Certification of a Qualified Health Plan. (1) An issuer, including a multi-state plan and a CO-OP, wanting to offer a qualified health plan on the KHBE during the initial open enrollment period shall submit a notice of intent Form KHBE-C1, incorporated by reference in Section 6 of this administrative regulation, to the Office.

(2) To participate on the KHBE an issuer, including a multi-state plan and a CO-OP, shall:

(a) Enter into a participation agreement with the Office;

(b) 1. Submit items as identified in subparagraph 2. of this paragraph, no later than:

a. June 1, 2013, for a plan year beginning on January 1, 2014; and

b. June 1, of the previous year for a plan year beginning in January 1, 2015, and thereafter; and

2. Submit to the Department of Insurance through the SERFF system:

a. Forms and rates for a QHP to be offered on the KHBE;

b. Plan management data templates; and

c. Application to offer a QHP on the KHBE;

(c) Have a certificate of authority issued by the Department of Insurance;

(d) Obtain approval of rates and forms from the Department of Insurance;

(e) 1. Comply with42 USC § 18021; and

2. Be in Good Standing;

(f) Charge the same premium for the same plan sold on the KHBE or outside the KHBE;

(g) Ensure that a cost-sharing requirement does not exceed a limit established in Section 1302(c)(1) of the Affordable Care Act;

(h)1. Be accredited or obtain accreditation in accordance with the timeline in 45 C.F.R. 155.1045(b) and the requirements in 45 C.F.R. 156.275; and

2. After obtaining accreditation, maintain accreditation as long as a QHP is offered on the KHBE; and

(i) Report to the KHBE, HHS, and the Department of Insurance, the transparency data required under 45 C.F.R. 156.220(a).

(3) If an issuer participates in the KHBE individual exchange, the issuer shall:

(a) Offer at least a:

1. QHP with a silver metal level of coverage;

2. QHP with a gold metal level of coverage with an embedded pediatric dental essential health benefit;

3. Catastrophic plan; and

4. Child-only plan to an individual under age twenty-one (21); and

(b) Comply with the requirements in 45 CFR 156, Subpart E.

(4) If an issuer participates in the KHBE SHOP, the issuer shall:

(a) Offer at least a:

1. QHP with a silver metal level of coverage;

2. QHP with a gold metal level of coverage;

(b) Ensure that a deductible meets the requirement identified in Section1302(c)(2) of the Affordable Care Act; and

(c) Comply with the requirements in 45 C.F.R. 155.725(b).

(5) If an application of an issuer to participate in the KHBE is denied by the KHBE, the KHBE shall issue a denial notice that provides:

(a) A reason for the denial;

(b) Appeal rights; and

(c) The opportunity to reapply.

(6) The KHBE shall certify a health plan offered by an issuer approved to participate on the KHBE if the health plan:

(a) Has obtained rate and form filing approval by the Department of Insurance;

(b) Excluding a pediatric dental essential health benefit identified in subsection (9) of this section, provides:

1. An essential health benefit approved for the Commonwealth of Kentucky by the Secretary of HHS;

2. A benefit in accordance with 45 C.F.R. 156.115;

3. Parity in a physical health and behavioral health service in accordance with 42 U.S.C. § 300gg–26; and

4. A metal level of coverage, unless the QHP is certified as a catastrophic plan;

(c) Does not include a:

1. Rider; or

2. A benefit in excess of an essential health benefit;

(d) Has a provider network approved by the Department of Insurance that shall:

1. Meet the provider network adequacy requirements established in KRS 304.17A-515 and 45 C.F.R. 156.230; and

2. Include an essential community provider in accordance with 45 C.F.R. 156.235; and

(e) Is offered in a service area in accordance with subsections (7) and (8) of this section.

(7) An issuer shall:

(a) Provide through SERFF a summary of benefits and coverage for a plan that it offers on the KHBE; and

(b) Offer a QHP in a statewide service area, except as allowed under subsection (8) of this section.

(8) An issuer may offer a QHP in a service area less than statewide if:

(a) There is a QHP available statewide;

(b) The issuer's service area includes, at a minimum, a health benefit plan region identified in HIPMC-R33, Health Benefit Plan Regions which is incorporated by reference in 806 KAR 17:005; and

(c) The issuer's service area is established in a nondiscriminatory manner without regard to:

1. Race;

2. Ethnicity;

3. Language;

4. Health status of an individual in a service area; or

5. A factor that excludes a high utilizing, high cost or medically-underserved population.

(9) A QHP shall not be required to provide a pediatric dental essential health benefit if:

(a) The KHBE has certified at least one stand-alone dental benefit plan that is available to supplement the QHP's coverage;

(b) The KHBE has determined that there is sufficient access to pediatric dental care; and

(c) The issuer discloses at the time it offers the QHP that the QHP does not provide the full range of pediatric essential dental health benefits.

(10) An issuer may offer a maximum of ___?___ QHPs per metal level of coverage.

(11) Within ninety (90) days of an issuer submitting the items identified in subsection (2)(b) of this section, the KHBE shall notify an issuer of a decision to:

(a) Approve certification of the QHP; or

(b) Deny certification of the QHP.

(12) If a QHP is denied certification by the KHBE, the KHBE shall issue a denial notice to the issuer that shall provide:

(a) A reason for the denial; and

(b) Appeal rights.

(13) (a) A QHP certification shall expire two (2) years after it is issued by the KHBE; or

(b) If the certification of a QHP offered on the SHOP expires prior to the annual renewal date of an enrolled group, the QHP certification may be extended to the annual renewal date of the enrolled group.

Section 3. Certification of a Qualified Dental Plan. (1) An issuer offering a qualified dental plan on the KHBE shall have a certificate of authority.

(2) Except as referenced in subsection (4) of this section, an issuer that has been qualified by the KHBE to offer a pediatric dental essential health benefit shall comply with the requirements for certification in Section 2 of this administrative regulation.

(3) A qualified dental plan shall:

(a) Be limited to a dental or oral health benefit;

(b) Include at a minimum a pediatric dental essential health benefit required under Section 1302(b)(1)(j) of the Affordable Care Act;

(c) Not provide a metal level of coverage as described in Section 1302(d) of the Affordable Care Act;

(d) Provide a level of coverage as required by 45 CFR 156.150;

(e) Have an annual limitation on cost sharing as required by 45 CFR 156.150;

(d) Not be a catastrophic plan as described in Section 1302(e) of the Affordable Care Act; and

(e) Not include a:

1. Rider; or

2. Benefit in excess of a pediatric dental essential health benefit.

(4) An issuer of a qualified dental plan shall not be required to:

(a) Submit a report on a quality improvement strategy in accordance with 45 C.F.R. 156.200(b)(5);

(b) Comply with:

1. The standards related to the risk-adjustment program under 45 C.F.R. 156.200(b)(7);

2. An accreditation requirement established in Section 2(2)(h) of this administrative regulation;

3. The annual limitation on cost-sharing in Section 1301(a)(1)(B) of the Affordable Care Act and 45 C.F.R. 156.2009b)(3);

4. A provider network requirement in Section 2(6)(d) of this administrative regulation; and

5. An essential community provider requirement in 45 C.F.R 156.235; and

(c) Provide to HHS the information related to a prescription drug specified in Section 6005 of the Affordable Care Act.

(5) An issuer of a qualified dental plan shall comply with:

(a) The provider network adequacy standards in KRS 304.17C-040;

(b) The requirements for stand-alone dental plans referenced in 45 C.F.R. 156 Subpart E.

Section 4. CO-OPs and Multi-State Plans.

Section 5. Appeals.

Section 6. Material Incorporated by Reference. (1) The following material is incorporated by reference:

(a) "Notice of Intent, Form KHBE-C1", January 2013 edition;

(b)

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of the Kentucky Health Benefit Exchange, 12 Mill Creek Park, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at _____.